



COCHISE COUNTY JAIL MEDICAL

REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) nasal decongestant to
painful chest

Date: 3/22/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kristina Booking #: 644

Inmate / Patient Date of Birth: 9/11/76

Please list any known drug allergies or circle NONE:

Nature of Complaint:

Please give me some pain/sinus pressure relief. Both my ears, my sinuses, head, eyes are painful with pressure but I cannot seem to loosen anything to cough or blow it out.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kristina Hills
Inmate/Patient's Signature

Date: 3/22/19

Held scheduled IBU 600mg - Administered

Date: 3/22/19

Witness Signature & call number

Decoret tabs per pp. lug



COCHISE COUNTY JAIL MEDICAL

REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/23/19 Cell Location: CB/3
Inmate/Patient Name: Hills, Kris Booking #: _____ / _____

Inmate / Patient Date of Birth: / /

Please list any known drug allergies or circle NONE:

Nature of Complaint:

I am suffering from Severe Sinus pressure and
Chest congestion. I am in desperate need of
your services as soon as it is convenient please.
Thank you so much.

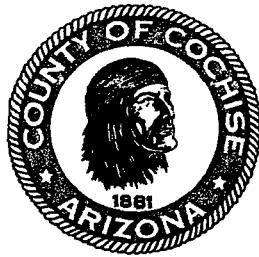
Decorel Forte Plus 99 800 mg

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the-counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Inmate/Patient's Signature Date: / /

bba
Witness Signature & call number

3,23,19
Date: / /



CB

COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/26/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 644

Inmate / Patient Date of Birth: 9/17/76
Please list any known drug allergies or circle NONE:

Nature of Complaint:

I have been asking for help with this cold since last week. There is fluid in my lungs & infection in my face & too much longer I might drown in it.

Doctor forte given 1/2oz [REDACTED]

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

KM Hills
Inmate/Patient's Signature

Date: 3/26/19

Witness Signature & call number Date: _____

You have received medications for 3 days. Please fill out a medical request form to be seen in medical if you are still needing medication. 3/26/19 Medical



COCHISE COUNTY JAIL MEDICAL

REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/26/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE.

Nature of Complaint:

I have been asking for help with this cold since last week. There is fluid in my lungs & infection in my face & too much longer I might drown in it.
Decadent forte give 10 decadent / 4pm daily

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

KM Hills Date: 3/26/19
Inmate/Patient's Signature

Witness Signature & call number Date: / /

You have received medications for 3 days. Please fill out a medical request form to be seen in medical if you are still needing medication. 3/26/19 Medical

Cochise County Jail Inmate Grievance – Level One

To: OFFICER ON DUTY Received By: _____ Date/Time: _____
From: Hills, Kris Booking #: 1044 Pod/Cell #: CB13 Date: 4/16/19
Inmate Name

I. Grievance (To be completed by Inmate): Describe the reasons and nature for your complaint.

Last night I was taken to Copper Queen Hospital where I was allegedly seen by medical professionals, but no one would let me see ANY paperwork (much less) keep a copy or even my bracelet.

II. Grievance (To be completed by Inmate): Document reasonable attempts to resolve complaint informally prior to filing this formal grievance.

I asked both medical staff @ the hospital & CCSO/CCJ officers for (AT LEAST) copies to which I was told the paperwork would be on file @ medical & is inaccessible to me?

III. Grievance (To be completed by Inmate): Explain your reasonable proposed resolution.

I would appreciate a copy of this grievance, a copy of the paperwork from last night's medical FARCE, & a response to this grievance PLEASE

K. M. Hills

Inmate Signature

4/16/19

Date

IV. Duty Officer's resolution (to be completed by duty officer prior to forwarding to Shift Supervisor):

on 4/16 Clark told me this is not a grievable issue & I would need to request such records after release, however, he said he didn't know if I could even get them then because he is unsure of medicals policy/procedure in such matters.

Officer's Signature

Date

Cochise County Jail Inmate Grievance – Level One

To: OFFICER ON DUTY Received By: _____ Date/Time: _____
From: HILLS, KRISTINA Booking #: 1644 CB13
Inmate Name Pod/Cell # Date

J.2. Grievance (To be completed by Inmate): Describe the reasons and nature for your complaint.

I. Grievance (To be completed by Inmate): Describe the reasons and nature for your complaint.

See attached Healthcare Request please. I ~~had~~ response to it when I handed it to the nurse, she handed it back to me told me I only had use of ice packs for 72 hours. The 72 hours are now past. She told me NOT to kick the door again ~~for medical emergencies~~ basically implied that because I did I would now have to accept the consequences (which is both obvious & irrelevant). I then began TIN the 17 page handbook to see what to do in a medical emergency because there IS NO intercom in the cells; No way to contact staff for help.

II. Grievance (To be completed by Inmate): Document reasonable attempts to resolve complaint informally prior to filing this formal grievance.

III. Grievance (To be completed by Inmate): Explain your reasonable proposed resolution.

Inmate Signature

Date

IV. Duty Officer's resolution (to be completed by duty officer prior to forwarding to Shift Supervisor):

Officer's Signature

Date _____

COCHISE COUNTY JAIL

INMATE REQUEST FORM

TO: CLARK 11	NAME & POD: HILLS, KRIS
SUBJECT:	BOOKING NUMBER: 10414
DATE & TIME RECEIVED: 4/16/19 1034	RECEIVED BY: 854

NATURE OF REQUEST:

Last night I was taken to Copper Queen Hospital where I was allegedly seen by medical professionals, but no one would let me see any paperwork much less keep a copy of even the "triage" or "services summary". Even my bracelet was cut off immediately. I asked BOTH medical staff @ the hospital & CCSO/CCT officers for (at least) copies to which I was told the paperwork would be on file @ CCT medical (& inaccessible to me?). And how exactly do I acquire this "medical record" once I am released? Or to what policy do I refer to do so?

DATE: 4/16/19

INMATE SIGNATURE: KRIS HILLS

DUTY OFFICER COMMENTS:

fail to
medical

OFFICER'S NAME

A#

SIGNED:

REPLY:

4/16/19 seen in medical by provider
McDowell

SIGNED:

DATE:



11

COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 4/16/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 1,644

Inmate / Patient Date of Birth: 9/17/76
Please list any known drug allergies or circle NONE:

Nature of Complaint

When I went to Copper Queen last night everyone refused me copies - medical & security staff BOTH, with the rationalization (excuse) that I cannot have them because they go in the medical "file". I am requesting copies from the triage & release summary both as well as the other paperwork pertaining to my experience last night with my E.R. visit. Thank you!

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris Hills
Inmate/Patient's Signature

Date: 4/16/19

Witness Signature & call number Date: _____ / _____ / _____



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 4/15/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 1644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complaint: complaint

I am having severe pain in the left side of my groin & a huge bump is protruding since this morning. I'm afraid to eat & make it worse. I can't sleep comfortably & its too large & painful to push in if it is a hernia.

Patient was sent out for further evaluation of an inguinal bulge.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris Hills
Inmate/Patient's Signature

Date: 4/15/19

Witness Signature & call number

John, RN

Date: 04/15/19



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/2/19 Cell Location: CB12

Inmate/Patient Name: Hills Booking #: 6441

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

NPSC

Nature of Complaint:

I had pelvic inflammatory disease the month before I came into jail. I did not finish my antibiotic before I was incarcerated again on 2/25 & I now have a painfully large lump in my GROIN.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

KM/H Date: 3/10/19
Inmate/Patient's Signature

3/10/19
Witness Signature & call number

NSC
112/13 75
924 980/0

Date: 3/10/19

Small enlarged lymph node in Pubic area. Has been shaving. Requests to see provider. Had PID recently.



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) ice pack

Date: 4/9/19 Cell Location: CB13

Inmate/Patient Name: Hills, Keis Booking #: 644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complaint: Complaint:

I slipped in the shower & the outer side of my right ankle has been aggravated painfully & it is swollen. ^{Again} May I please use an ice pack to minimize the pain & swelling?

I would also like a copy of this request per handbook policy. Thank you.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

K.M. Hills Date: 4/9/19
Inmate/Patient's Signature

Witness Signature & call number

Date: / /



COCHISE COUNTY JAIL MEDICAL REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) ice pack

Date: 3/14/19 Cell Location: CB12

Inmate/Patient Name: Hills, Kris Booking #: 1044

Inmate / Patient Date of Birth: 9/17/70

Please list any known drug allergies or circle NONE:

Nature of Complaint:

ice pack for my feet
very painful.
daily struggle.

3/14/19 given

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

K.M. Hills Date: 3/14/19
Inmate/Patient's Signature

Witness Signature & call number Date: _____ / _____ / _____



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) ice pack

Date: 3/13/19 Cell Location: 012

Inmate/Patient Name: Hills Booking #: 644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complain:

ice pack please

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these sevices and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inamte will not sign, please have an officer sign below in the witness signature spot.

John Hills
Inmate/Patient's Signature

Date: 3/13/19

Witness Signature & call number

Date: / /

ice pk provided
ice pk provided



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) daily ice packs please

Date: 3/12/2019 Cell Location: CB12

Inmate/Patient Name: Hills, Kristina Booking #: 644

& bottom bunk bottom tier
chrono

Inmate / Patient Date of Birth: 9/17/1976

Please list any known drug allergies or circle NONE:

Nature of Complaint:

At the time of my intake I notified medical of an issue with my right ankle. I've repeatedly needed ice packs to function. Friday morning I was given directive to remove my clothes from the upstairs rail due to inspection. I slipped on the steps on the way down & believe I fractured the ankle severely.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kristina Hills
Inmate/Patient's Signature

Date: 3/12/2019

Witness Signature & call number

Date: / /

evaluate at NSC

ice-wk provider



PS

COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) ice pack

Date: 3/21/19 Cell Location: CB 12

Inmate/Patient Name: Hills Booking #: 644

Inmate / Patient Date of Birth: 9/17/76
Please list any known drug allergies or circle NONE:

Nature of Complaint:

(2) Ice packs for foot/ankle

1 for left foot

1 for right ankle

I'm thinking I
need to be seen
because the
condition is no
improving

Roommate says I'm crying in my
sleep.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Hills
Inmate/Patient's Signature

Date: 3/21/19

Witness Signature & call number

Date: / /

3/3/19 Requested inmate be brought to medical
twice. Not brought.

3/4/19 & brought per OP

* 1 ice pack
given



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/1/19 Cell Location: CB12

Inmate/Patient Name: Hills Booking #: 6441

Inmate / Patient Date of Birth: 9/17/76
Please list any known drug allergies or circle NONE

Nature of Complaint:

My feet are both painful & swollen

Ice pack please.
Is there any way to make this a
nightly thing without the daily
paper request?

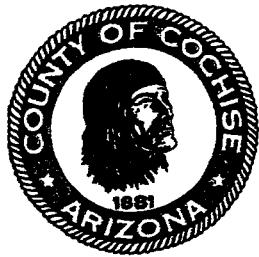
By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Km Hills Date: 3/1/19
Inmate/Patient's Signature

Witness Signature & call number

Date: _____/_____/_____

Ice pack given



COCHISE COUNTY JAIL MEDICAL

REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call _____ Dentist _____ Prescription Refill _____
Mental Health Other (specify) ice pack

Date: 2/28/19 Cell Location: _____

Inmate/Patient Name: Kris THUS Booking #: 1664

NN# 644

Inmate / Patient Date of Birth: 9/17/78

Please list any known drug allergies or circle NONE:

Nature of Complaint:

Ice pack please
swollen ankle
broken toe

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris
Inmate/Patient's Signature

Date: 2/28/19

Witness Signature & call number

Date:

ice pack
for ankle pain
please provide
ice pack



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

COPY

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) ice pack

Date: 4/9/19 Cell Location: CB13

Inmate/Patient Name: Hills, Keis Booking #: 644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complaint: Complaint:

I slipped in the shower & the outer side of my right ankle has been aggravated painfully & it is swollen. ^{AGAIN} May I please use an ice pack to minimize the pain & swelling?

I would also like a copy of this request per handbook policy. Thank you.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

K.M. Hills Date: 4/9/19
Inmate/Patient's Signature

Witness Signature & call number

Date: _____ / _____ / _____



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

11
COPY
PLEASE

vices as follows (check one)

Dentist

Prescription Refill

Other (specify)

copy of grievances

Cell Location: CB13

Hills, Kristina

Booking #: 1644

Birth: 9/17/1976

Drug allergies or circle NONE:

I agreed I would not do grievances anymore because Clark said he would respond to all my request. ~~over~~ forms have submitted AT LEAST 3 grievances to medical, none of which have been returned (or answered with copy). Please return them to me ASAP. They all all from April. I would like a copy of this also. Thanks.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

KM Hills
Inmate/Patient's Signature

Date: 5/4/2019

Witness Signature & call number

COPY

Date: / /



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE
Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) COPIES

Date: 4/16/19 Cell Location: CB13

Inmate/Patient Name: Hill, K Booking #: 1644

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complaint:

complaint
The Policy handbook states that I should receive copies of all my grievances, but I have not received any copies of any of my medical grievances so I'm not sure they are being acknowledged much less validated.
Please return copies to me immediately. Thank you.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

K. Hill
Inmate/Patient's Signature

Date: 4/16/19

Date: / /

Witness Signature & call number

Cochise County Jail Inmate Grievance – Level One

To: SUPERVISOR ON DUTY Received By: J. Romo Date/Time: 4/16/19
From: HILLS, KRIS Booking #: 644 CB13
Inmate Name Pod/Cell #: 4 Date 4/16/19

I. Grievance (To be completed by Inmate): Describe the reasons and nature for your complaint.

I have not received copies of the last 3 grievance forms I submitted so I'm unsure if they are even being acknowledged or validated.

II. Grievance (To be completed by Inmate): Document reasonable attempts to resolve complaint informally prior to filing this formal grievance.

I spoke with Olson. She said she would look into it because there are a lot of "New" officers being trained so they may not be aware of policy re: grievance copies.

III. Grievance (To be completed by Inmate): Explain your reasonable proposed resolution.

I should receive copies of all my grievance forms especially those of a medical nature.

KM Hills
Inmate Signature

4/16/19
Date

IV. Duty Officer's resolution (to be completed by duty officer prior to forwarding to Shift Supervisor):

Forward to medical. Advised Cpl. Clark.
She put in a grievance form on 4-8-19. to medical
area

J. Romo
Officer's Signature

4-16-19
Date

Submitted &
Med griev 4.
Next copies

COCHISE COUNTY JAIL

INMATE REQUEST FORM

TO: Officer on Duty	NAME & POD: Hills CB13
SUBJECT: I'm Requests vs Grievance	BOOKING NUMBER: 6044
DATE & TIME RECEIVED: 4-23-19 1400	RECEIVED BY: 857

NATURE OF REQUEST: SIR - I'm not getting responses to my request forms & I don't know what to do. The only way I seem to be certain to get acknowledged at all is when I do a grievance (& half the time even then my grievances disappear). So I need to know two things #1. How many days does it take to get a request form back? I can't find it in policy. #2. Does the agreement still stand? That if I avoid the grievances & just do request forms will it still stand?

DATE: 4/23/19 INMATE SIGNATURE: K M Hills

DUTY OFFICER COMMENTS:

RESPONSE TIMES MAY DIFFER
DEPENDING ON WHO IT WAS FORWARDED
TO AND THEIR SCHEDULE.

OFFICER'S NAME J. Rubio

A#1829 SIGNED: J. Rubio

REPLY:

There has been no change in the grievance process

SIGNED:

DATE:

COCHISE COUNTY JAIL

INMATE REQUEST FORM

TO: OFFICER ON DUTY	NAME & POD: HILLS CB13
SUBJECT: AIR FLOW IN POD	BOOKING NUMBER: 0001044
DATE & TIME RECEIVED:	RECEIVED BY:

NATURE OF REQUEST: Please have mercy - I have spent the last 3 nights in my underwear (trying to sleep) on the concrete floor because it is so hot in the cell.

I am asking for simple air flow please.

DATE:	INMATE SIGNATURE: Km Hills CB/3
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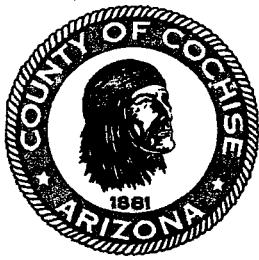
DUTY OFFICER COMMENTS:

Thermostat is set at 74°

OFFICER'S NAME	A#	SIGNED:
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REPLY:

SIGNED:	DATE:
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COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 4/1/2019 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 10441

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of complaint:

Although I pay for my prescriptions & rely on your medical staff to administer accordingly, I am & have been missing prescribed doses frequently. I don't understand why. The prednisone was only once a day, & yesterday my inhaler could not be located AT ALL. I wait, as told,

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris H
Inmate/Patient's Signature

Date: 4/11/19

over 4/11/19

Witness Signature & call number Date: / /



COCHISE COUNTY JAIL MEDICAL REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 4/8/19 Cell Location: CB 1

Inmate/Patient Name: Eve McCoy Booking #: 151405

Inmate / Patient Date of Birth: 02/01/1974

Please list any known drug allergies or circle NONE:

Dentist

Nature of Complaint:

May I please see the dentist. I have two teeth that need to be pulled desperately.
Thank you.

4/11/19 - Per Protocol: Placed on the dental list ONLY if severe periodontal disease, recurrent infections while incarcerated; or abscess.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Eve K. McCoy
Inmate/Patient's Signature

Date: 04/08/2019

Witness Signature & call number

Date: _____ / _____ / _____



COCHISE COUNTY JAIL MEDICAL REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/23/19 Cell Location: CB 13

Inmate/Patient Name: Hills KRS Booking #: 60441

Inmate / Patient Date of Birth: 9/16/76

Please list any known drug allergies or circle NONE:

Nature of Complaint:

Please help my pain & sickness by giving me the 2 cough & cold pills that relieved the pressure in my neck.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these sevices and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inamte will not sign, please have an officer sign below in the witness signature spot.

Kmthil
Inmate/Patient's Signature

Date: 3/23/19

Witness Signature & call number

Date: _____ / _____ / _____

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Jens
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COCHISE COUNTY JAIL MEDICAL REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/24/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking #: 1044

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Nature of Complaint:

Is there anything else you can give me while you have me waiting to see the provider? I'm in a lot of pain, my back & chest hurts & my balance is off. I fell twice today. I'm short on breath, lost my voice, & can barely hear

324 Decorte Forte Revs given @ 1930 C.O. mon 6 PM
By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris Hills
Inmate/Patient's Signature

Date: 3/24/19

Date: _____ / _____ / _____
Witness Signature & call number



COCHISE COUNTY JAIL MEDICAL REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: _____ Cell Location: CB

Inmate/Patient Name: _____ Booking # 12441 _____

Inmate / Patient Date of Birth: 9/17/76

Please list any known drug allergies or circle NONE:

Need antibiotics

Nature of Complaint:

Is there any possible way for me to get any antibiotics for my viral infection? I am feeling horrible & feel the only way for me to get better is by antibiotics please.

Thank you,

Placed on sick call list per request. Bbaud

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Ken Hillo Date: 3/24/19
Inmate/Patient's Signature

Date: _____ / _____ / _____
Witness Signature & call number



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/25/19 Cell Location: CB13

Inmate/Patient Name: Hills, Kris Booking # 144

Inmate / Patient Date of Birth: 9/17/74

Please list any known drug allergies or circle NONE:

Nature of Complaint:

I need relief from these
old symptoms while I
wait to see the provider.
Please I haven't been able
to eat & the left side
of my head is numb to the
touch

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawal however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris Hills
Inmate/Patient's Signature

Date: 3/25/19

Witness Signature & call number _____ Date: _____ / _____ / _____

Decorel Forte Plus given @ 1845 C. O. mail P/N



COCHISE COUNTY JAIL MEDICAL
REQUEST FOR HEALTHCARE

Medical care will never be refused to any inmate

I request Healthcare services as follows (check one)

Sick Call Dentist Prescription Refill
 Mental Health Other (specify) _____

Date: 3/26/19 Cell Location: CB13

Inmate/Patient Name: Hills Kris Booking #: 614

Inmate / Patient Date of Birth: 2/17/76
Please list any known drug allergies or circle NONE:

Nature of Complaint:

Again, I need to be put
on the list to see
a doctor. I can't keep up
because the symptoms are
worse.

By my signature below, I hereby indicate that I understand that I may be charged \$10.00 for Health care services obtained at my request, \$10.00 for each prescription, and a \$1.00 charge for each over-the counter medication. Those inmates who do not have any money in their account will be seen by the medical staff & a negative balance will be placed on the account. I understand that any charge for these services and/or prescriptions shall be withdrawn automatically from my trust fund account here at the Cochise County Jail. I will not receive a receipt for this withdrawl however; I may review the balance of my trust account as provided by facility procedures. In the event an inmate will not sign, please have an officer sign below in the witness signature spot.

Kris
Inmate/Patient's Signature

Date: 3/26/19

Witness Signature & call number: _____ Date: _____ / _____ / _____

NPSL